JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY VOL. 64, NO. 20, 2014

ISSN 0735-1097/$36.00
PUBLISHED BY ELSEVIER INC. http://dx.doi.org/10.1016/j.jacc.2014.09.025

The Push to Subspecialize

Choosing a Career in Cardiology

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> *"There are, in truth, no specialties in medicine, since to know fully many of the most important diseases a man must be familiar with their manifestations in many organs."*
> —William Osler (1)

"What do you want to be when you grow up?" is a familiar refrain of childhood. For those of us fortunate enough to be accepted into medical school, the question evolves into "What kind of doctor do you want to be?"

Some physicians seem to know from birth exactly in what specialty they want to focus their lives. Perhaps these individuals had a particular childhood experience that made them want to pursue a career in percutaneous interventions of structural heart disease, specifically of the pulmonary valve. However, the vast majority of us require time, experience, guidance, and discernment before making a choice. It is the latter group I am addressing, although I suspect many, if not most, of the former group may change or reconsider their plans along the way.

I did not know what I wanted to be when I grew up. While attending university, I majored in both general sciences and humanities. Ultimately, I was drawn to the biological and anatomical sciences, and I applied to medical school. After the varied and valuable experiences of clinical clerkship, I chose a residency in internal medicine, because it was the most open-ended, noncommittal decision I could make. Yet again, I was inundated with questions about future plans. With the residency match deadline fast approaching, I agonized for months before applying to a general cardiology fellowship.

Once accepted and comfortably ensconced in the cocoon of cardiology fellowship, including daily rounds, journal clubs, research projects, and evening conferences, I believed that I would no longer be subjected to difficult and restrictive decisions over further specialization. At least not right away. I felt an immense relief that I was finally content with my career path. I was going to be a cardiologist. However, the relief was short lived. At periodic evaluations, my program directors asked, "What do you want to subspecialize in?" Another attending staff told me, "You need to brand yourself. Are you a cath guy or do you want to pursue a path in noninvasive cardiology? You need to know. People need to know." I suddenly became aware of the career paths of the other trainees around me. By the end of first year of cardiology fellowship, some fellows had already applied for further specialty training. Others were gunning for competitive fellowship spots in top institutions. I had not yet done subspecialty rotations in electrophysiology, nuclear cardiology, or congenital heart disease. How was I supposed to choose a career path? Colleagues and supervisors were trying to direct me, but I just wanted to enjoy the experience. "If you want a career in academia," an adviser told me, "you had better start making decisions soon."

There are many factors that contribute to a career choice for a cardiology trainee. Job opportunities, potential professional satisfaction, family circumstances, geographical constraints, and, yes, money and prestige are all important considerations that guide decision making. For those wishing to obtain employment in a competitive field, there is tremendous pressure to subspecialize and often sub-subspecialize in a niche area—with extra training and temporary relocation usually required. Academic settings in particular often mandate or desire additional qualifications and a demonstrated interest in an underexplored or "hot" area of cardiology. However, there is also a growing demand from community

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and peripheral cardiology departments for additional skills and further specialization, such as higher level training in cardiac imaging (echocardiography, cardiac computed tomography, and/or cardiac magnetic resonance). As one of my colleagues said, "Gone are the days of the general cardiologist."

There is no doubt that specialization in cardiology is necessary, as the field is becoming increasingly more technologically sophisticated, the rate of scientific advancement is accelerating, patients are becoming more complex, and time pressures are mounting. Yet, the danger inherent in subspecialization is that we divide the heart into its component parts ("I am just an electrician," an electrophysiologist once told me, or a "plumber," others have opined). Thus, they do not have the opportunity to see the entire system, or the patient, as a whole.

The push to subspecialize also likely reflects changing trends in society. Trainees more often are choosing modern "lifestyle-based careers," rather than careers with the significant burden of longitudinal, holistic patient care. In essence, they are eschewing responsibility for comfort. As a result, medical residency programs are seeing declining enrollments in primary care specialties, in favor of specialty programs. This is not a new phenomenon. More than 35 years ago, after a challenging internship year, the protagonist in Samuel Shem's *The House of God* decided to switch into a more lifestyle-friendly career by pursuing an "NPC," as in a No Patient Care specialty (2).

As for me, I continue to enjoy exploring the world of cardiology, while not declaring a specific area of interest. I will decide on which subspecialty—if any—I choose to pursue at a later time. However, I am interested in a career in academia and, although I will likely choose a focus mostly out of professional interest, ultimately I need a job.

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